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PSYCHO-ANALYSIS.

Definition, Technique and Mode of Action.

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Psycho-Analysis Defined.—Psycho-analysis is a science as well as an art. As a science it deals with all those phenomena that may be regarded as the manifestations of unconscious mental activities in human beings. Psychology, as the term is generally employed, means the science of the conscious mental activities. Unconscious mental activities differ from conscious mental activities in several very important respects besides that of being unconscious *i.e.* going on without the individual's cognizance. A very brief definition of "psycho-analysis" is "the psychology of the unconscious." A number of very prominent psychologists have denied the existence of the "unconscious." They say that all psychical processes are conscious processes and that there are no psychical processes which are not conscious. But assertion is no proof. Most modern psychologists, especially those who have been sufficiently fair-minded and unprejudiced to consider the facts presented by psycho-analysts, admit the existence of unconscious mental activities. The conviction that there are unconscious psychic activities forced itself upon some psychologists even before the days of psycho-analysis. Our reasons for the belief in the unconscious are numerous and convincing and will be presented in detail in a future study. For the present we will take it for granted and refer the general reader only to his own recollection of how many things he himself did for which he could give no better explanation than that he did them "unconsciously." Like the Darwinian theory and the atomic theory of the constitution of matter and the theory of the universal ether, and other scientific theories, the conception of "the un-

conscious" is founded upon the application of logical principles to the explanation of a large number of empirically obtained facts which cannot be explained in any other way than by the assumption of such unconscious psychic activities. I dwell upon this now because the unconscious is the basis on which psycho-analysis as an art is founded. If the existence of unconscious mental activities can be disproved our whole theory falls to the ground.

As an art psycho-analysis is the application of the teachings of psychoanalytic science to the investigation of the unconscious mental activities of human beings, especially those who suffer from that large class of distressing ailments known as "psychoneuroses" or "nervousness." The most common of these ailments are the many forms of hysteria (muscular, sensory, emotional, etc.), phobias of all sorts (e. g. the fear of being alone, fear of darkness, fear of crowds, fear of thunder, fear of knives, etc.), obsessive acts (i. e., muscular twitches of small or large groups of muscles) and obsessive thoughts (e. g., an obsessive belief that one has committed a crime that he has not). These cases are most frequently spoken of by general practitioners as "neurasthenia" or as "psychasthenia." Psycho-analysts, following Professor Freud, reserve the term "neurasthenia" to a class of cases presenting a certain group of symptoms as a sequel to excessive masturbation. These cases are really very scarce; they are not cases for the psycho-analyst. Another very large group of cases that come under the notice of the general practitioner and the neurologist but which are not true psychoneuroses, though they are mostly described as being "hysterical" or "nervous," are those who suffer from what we call "apprehension neuroses" or "actual neuroses." These are all cases of unsatisfied sex hunger; they are the men and women who suffer the consequences of some form of contraceptive coitus (e. g., c. interruptus, c. condomatus, c. reservatus), or of frustrated sexual excitement or of inability to satisfy the sexual urge (e. g., widowhood, bachelorship in a very religious man, etc.) These patients are not benefitted by psycho-analysis unless, as is very often the case, they are also hysterical or psychoneurotic. Mixed cases, i. e., apprehension neurosis combined with psychoneurosis, are the rule, but pure cases unquestionably occur.

Psycho-analysis is not merely a method of investigating the psychoneurotic patient's mind for the purpose of making a diagnosis and differentiating the condition from an organic disease or from a psychosis, but is also *a method of treatment*. The

successful investigation of the neurotic symptoms cures them. How psycho-analysis does this is the subject of this paper. A measurably full explanation of the psychology of the evolution of a psychoneurosis i. e. the explanation of how a psychoneurosis is brought about, will be given in subsequent essays. In this paper I shall explain only as much of the theory as is necessary to an understanding of how the cure is brought about. I shall also give a simple and brief description of the technique of the method, i. e. how to do it.

Fundamental Principles.—As a result of the patient labors of earnest and conscientious psycho-analysts the world over, especially Freud, Stekel, Ferenczi, Sadger, Rank, Pfister, Jones, Hitschmann, Putnam and others, we have reached the following important conclusions: that the symptoms of the psychoneurotic are the psychic or somatic manifestations of the workings of the unconscious mind; that they are the expression of unconscious “complexes” dominating the soul; that these “complexes” (a term coined by Jung and retained for convenience) are desires that the individual has “repressed” (i. e. forced out of his consciousness) because they are in conflict with his ethical, moral or religious concepts. (To simplify matters we shall define a “complex” as a motif or motive;—a lover’s conduct in his daily life, e. g. the disposal of his leisure hours, will be determined by his “love complex”; a politician’s vote, even on important matters, will be determined by his “political complex” more than by his reason, etc.) All ordinary individuals, i. e. all but geniuses and criminals, try to live up to the standard set for them by the community, to be like others, to approve what others approve and to condemn what others condemn. The psychoneurotic individual is one who tries to do likewise but for some reason unknown to him cannot. He feels that something is wrong; he cannot be and do what society says he ought to be and do. Society says that it is wicked, criminal, unnatural, irreligious, monstrous to have certain desires or impulses which he feels he has and which he therefore finds painful and which he consequently strives to force out of his mind, to consider as non-existent, i. e. he tries to “repress” them. (Caution: to “repress” is a wholly different process from to “suppress,”—the latter term means to conceal, to refuse to divulge.) As long as he is conscious of these forbidden, though natural, desires he is at war with himself, he is in a state of mental conflict. Note, by way of example, the fearful state of mind of Brutus (in Shakespeare’s

"Julius Caesar") after he consented to join the conspirators to assassinate Caesar, or the state of mind of Macbeth after the weird sisters have suggested to him the murder of his king. Our future psychoneurotic is in a similar quandary. He differs from the criminal in that he lacks the courage to commit the evil deed, to satisfy his forbidden desire. He fears himself, his conscience, the vengeance of the community, his God. He hates the evil things he desires because he wants to think well of himself and wants to be well thought of by others and wants to go to heaven. So he strives to force the evil thing out of his mind. But these impulses and desires are instinctive, natural, and crave to be satisfied; they may be expelled from consciousness into the secret recesses of the mind, but they are not destroyed; though they are leashed, they are continually struggling to be free, to be satisfied. The host must be constantly on his guard against his unwelcome guests and when he has forced them out of doors he must continually keep the door barred against them. This requires a constant watchfulness, a constant expenditure of psychic energy. A patient, a girl of 17, told me only yesterday that while she is at work she is constantly thinking that she must not permit herself to think of the imagined crime she had committed,—of having forged her employer's name to a note for \$50,000.00! Another patient, a young man of 22, told me to-day, of being constantly on the alert against the idea of pollutions entering his mind. These neurotics are all conscious of the fact that they are not themselves,—as if someone else were master of their minds. And just as soon as they are off their guard, especially in sleep, the repressed complex manifests itself, either as a symptom or a dream. The more intelligent the person is and the more reprehensible the desire that he is repressing, the more disguised will the symptom or dream be. The ejected intruder seeks re-entry into consciousness in disguise. All this will be explained when we discuss the formation of dreams and symptoms.

Historical.—Until recently the psychoneuroses were the despair of physicians. No one knew what hysteria is, how the patients came by it and how they could be cured of it. For centuries it was believed that hysteria was a disease of women only and that it was due to the wanderings of the uterus about the body; that is why the disease was called "hysteria," "hystera" being the Greek word for "womb." Other equally absurd theories have been entertained from time to time. But during the past

forty years neurologists and psychiatrists have come to the conclusion, now generally accepted, that hysteria (really all the psychoneuroses) is a psychogenic disease, i. e. that the symptoms of the disease are the results of ideas, and that these ideas are of a strongly emotional nature. But this knowledge did not result in much practical good to the patients. Even to-day the general practitioner and most neurologists are helpless in the presence of all but the mildest cases of hysteria. They still recommend cold baths, rest cure, change of climate, ocean voyages, massage and disgusting medicines, and when all these fail they send the patient elsewhere. That is why the psychoneuroses have been very appropriately called the step-children of medical science. The patients were regarded as malingerers, base deceivers, who were more entitled to the whip than to sympathy. But to-day all this is changed. About 1880 Dr. Joseph Breuer, a name that will live forever, had a hysterical girl under his care in whom he took a genuine human interest and was thus led to make certain observations which he imparted to his friend and colleague, Dr. Sigmund Freud, the most brilliant thinker of modern times. Together they studied the symptoms of their hysterical patients and finally reached certain conclusions which they published in a monograph, "On the Psychic Mechanism of Hysterical Phenomena" (1893).

The conclusions these two pioneers then announced may be briefly summarized as follows: that many hysterical symptoms are brought about by the occurrence of a strongly emotional idea in a person while he is in a somnolent condition; if the emotion is not discharged or disposed of in the normal way it transforms or translates itself into bodily or mental symptoms; a cure can be brought about by helping the patient to recall to memory the forgotten idea and the circumstances that gave rise to it and thus enabling the patient to give vent to the pent up emotion. Freud expressed in the formula that the patient suffers from reminiscences. The forgotten traumatic situation was recalled to the patient's memory by putting her (or him) into a hypnotic sleep and asking her (or him) to concentrate on the commencement of the particular symptoms under investigation and to tell everything he (or she) saw and recollected. In this way the patient lived over again his past and, when aroused from sleep, was acquainted with what had been brought out and given an opportunity to give vent to the long-repressed emotions in speech and action. This method of treatment, called by the first patients "the talking cure"

or "chimney-sweeping," was termed by the illustrious discoverers "the cathartic method" ("katharos" being the Greek word for "pure;"—purification by speech). The essentials of this theory were the conception of a psychic trauma, the hypnotic (somnolent) state, the repression, conversion of the affect (emotion) into bodily or mental symptoms, hypnotism and abreaction through speech. Breuer went no further than this. Freud, however, continued his investigations and found that the matter was not so simple as they had thought, that some patients could not be hypnotized; that some patients could not or would not remember painful experiences even though they were hypnotized, that even if they recalled any such incidents in the hypnotic state they professed to know nothing about them afterwards, that in many cases no traumatic incidents could be determined and that some of the so-called traumata (shocks) were not at all shocking to some patients. These investigations led him to new and far-reaching conclusions and led to the evolution of a new method of treatment—without the aid of hypnotism—the method of psycho-analysis.

The Technique.—Psycho-analysis is a very trying, difficult and technical procedure. The rules of procedure have not been systematized and every analyst must learn the technique for himself. Experience is the best teacher; printed instructions are of no more value for successful practice than corresponding rules are to a surgeon. Combined with actual practice the hints thrown out by such writers as Freud, Ferenczi and Pfister are of the greatest value. Unless one can read these writers in the original or in good translations we would advise him not to meddle with such a delicate instrument as the human soul, especially a diseased human soul,—certainly not until he has himself gone through a psycho-analysis by a psycho-analyst. An analyst who is not the master of his own mind, who has not studied the residua at the bottom of his own soul, who has not his own complexes under control, can accomplish very little with others. In what follows I shall briefly describe the technique of psycho-analysis as I practice it.

First I satisfy myself to the best of my ability that the patient is really suffering from a psychoneurosis and not from a psychosis or an organic disease. An ideal case would be one in which the diagnosis had been made by several other physicians. I do not, however, agree with those analysts who say that the analyst should not make his own physical examination and diag-

nosis. It satisfies me and puts me in a position to answer the patient's doubts as to the psychic character of his symptoms. When I am older in practice I may think differently.

Then I explain to the patient as simply and as briefly as possible the nature of a psychoneurosis, the theory of unconscious mental activities, and the method of treatment. All this is very puzzling to him at first and he has many questions to ask; he is very skeptical and is sure to throw out hints questioning your honesty and sincerity. It is no good arguing with a neurotic at this stage of the treatment; assure him that his confidence or skepticism are utterly immaterial and insignificant. This disposed of we discuss terms. The psycho-analyst must be able to do this in a thoroughly sensible and business-like manner free from the ordinary physician's conventional reticence about money matters. If he has gone through an analysis he will be able to do this. I insist on not less than three sessions a week, on alternate days, of not less than one hour's duration each, at so-and-so much per session, payable weekly or monthly. If you allow bills to grow too large you will lose both money and patient. The fee must be commensurate with the patient's means.* The patient is assigned his days and his hour and is impressed with the fact that these hours are his and that he must pay for them whether he keeps his appointments or not. Charity cases or free cases are usually very unsatisfactory patients, but now and then one comes across a notable exception; besides, such patients may repay in scientific interest and may be the means of giving the young analyst his experience. The poor must—here as elsewhere—make content with their fortunes fit.

An experienced analyst will never venture to predict how long the treatment will last. It is my habit to say that the average case lasts from four to eight months but that there are cases that are cured in a few hours or in a few weeks or months, and that very obstinate or severe cases require two or three years; that all patients are benefited by the treatment even if they are not wholly cured; that my efforts are chiefly devoted to reconcile the patient to life, to enable him to resume his work, to help him

* If the patient feels that he or his relations are making a sacrifice in the effort to cure him it is an incentive to honest and persevering and conscientious psycho-analysis. A sentimental girl or woman who can easily afford to spend the money it costs will dawdle away her time—and the doctor's—because she enjoys his "charming company" and the "delightful talks."

take his place in the world and to relieve him of his sufferings. Professor Freud advises his patients to take a two-weeks' trial course. In my hands this suggestion does not work out well, perhaps because I do not see the patients often enough. Transferences are not so easily established here as abroad; our girls are more secretive, and our parents are more cautious in parting with their money.

These preliminary matters disposed of, and being now alone with the patient, I explain to him the difference between a "functional" and an "organic" disease, the psychogenetic or ideogenetic nature of hysterical or psychoneurotic symptoms, the dynamic quality of our desires or motives, and the functions of the unconscious mind. Unless these matters are explained the patients are suspicious and skeptical; they all suspect the psycho-analyst of being a Christian Scientist in disguise or a hypnotist. Having satisfied them that I am neither, I assure them that my work will be limited to helping them to study themselves, to investigate their mental workings, to discover their true motives and desires; that the object of this investigation is to make them masters of themselves by learning to know their hidden motives and how to control and dispose of them; that these hidden or repressed motives can be discovered by the process of continuous associations by virtue of the fact that these "complexes" or desires have a strong dynamic quality, are always striving to enter consciousness, always struggling for motor expression, influencing our every thought and action. Where possible I give the patient such homely and simple illustrations of these phenomena from every day life as will appeal to his intelligence.

I then instruct the patient as follows: "You have the liberty of this room; here you may sit, stand, or walk about as you please; but I prefer you to lie in this comfortable Morris-chair with your back towards me; if possible you will forget that I am in the room and watching you; you are to relax your muscles as completely as possible and try to disregard what you see in the room or through the window and pay no attention to noises in the street; all you have to do is to speak, to speak right on, to speak every thought that comes into your mind, no matter whether the particular thought seem to you immaterial, meaningless, foolish, trivial, stupid, funny, disgusting, shameful or painful; in other words you are to exercise no choice whatsoever in the thoughts that you give utterance to; let me be the sole judge as to the value or

relevance of the matter you bring forth; remember that you are not here to be judged or censured or praised; that you are only studying yourself and that you have to give vocal utterance to your thoughts because I cannot otherwise know what the things you think of are. It is furthermore important that you speak your thoughts as they come to you, not changing the words or the grammatical construction of your sentences. The promptness and thoroughness with which you will be cured will depend entirely on how faithfully you obey these rules. You may begin with the history of your ailment or the story of your life, as you prefer; after this you are to choose the subjects for your talks at each session for yourself."

The analyst must give his undivided attention to the patient, giving heedful note to his every word and gesture; much can be learned from the patient's facial expression and unconscious acts, e. g. humming, tapping, drawing or writing on the arm of the chair, etc. For this purpose the analyst seats himself comfortably behind and to the side of the patient at his desk, relaxes mentally and physically and puts all of his own matters out of his mind. If he likes—and if the patient have no objections—the analyst may from time to time jot down a few important data; but on the whole I think it better not to do so. In my experience the patient stops speaking while the analyst is writing, his thoughts are diverted, and the analyst easily falls into error in his choice of data and learns to depend on his notebook instead of on his memory. Wherever the analyst notices any gaps, uncertainties, contradictions, inconsistencies in the patient's story he chooses the first favorable opportunity to question him as to these. The analyst must never forget that the patient's thoughts are his symptoms, his temporary and transitory substitutes for the repressed matters that the analyst is in search of; that his task is to interpret these thoughts in terms of the repressed complexes; that for the successful accomplishment of this difficult and delicate task, which has now become a solemn obligation, he must take into account all of the patient's free associations, his dreams, his reveries and fantasies, his symptoms, his unconscious acts and his "misdoings" (a term that I suggest for that large class of actions embraced under the German word "Fehlhandlungen" and including such phenomena as slips of the tongue, mishearing, mislaying of objects, temporary forgetting, errors in recognition of persons or objects, misspeaking, etc.). The analyst's stock of

patience and sympathy must be inexhaustible; he must never for a moment lose sight of the fact that he is dealing with an invalid; he must not be annoyed or irritated by the patient's vagaries and eccentricities; he must always remember that the patient's every manifestation is a symptom, be it volubility or reticence, hopefulness or discouragement, joyousness or depression, amiability or crabbedness, friendliness or hostility, punctuality or dilatoriness, industriousness or laziness, etc. The analyst must not love his patient nor hate him; must not relieve him of his duties and responsibilities or solve his problems. In all but really important matters, e. g. choosing a profession or selecting a wife, etc., the patient must be taught and encouraged to depend on himself; in important matters he must make no step until he is cured. The analyst must approach each case free from any preconceptions or hastily formed conclusions not only as regards the case as a whole but as regards each symptom, and he must carefully avoid anything resembling suggestion, hypnotism or persuasion. The analyst's effort should be directed to recognizing the manifestations of transference and resistance, pointing them out to the patient and thus enabling him to overcome them, and to interpreting the material placed at his disposal by the patient's free associations and conduct.

During the first few weeks of treatment the analyst should play an almost wholly passive rôle, devoting himself to eliciting the patient's life history, etc., in as detailed a manner as possible. This is the time during which the patient must form an attachment for the analyst and for the treatment. Without this rapport nothing will come of the treatment. As the patient speaks the analyst follows him step by step and identifies himself with him and thus penetrates the innermost recesses of the patient's soul. In this way the analyst can reconstruct the patient's mental evolution, the meaning and causes of his symptoms and characteristics. Related ideas will associate themselves spontaneously in the mind of the analyst if he will learn to listen to the patient's data without any effort, just letting the associations sink into his mind.

The patient manifests resistance or antagonism to the treatment when he stops speaking and insists that nothing enters his mind, when he ceases to dream or forgets his dreams, when he has so many and such long and complicated dreams that there is no time for their analysis, when he ceases to be punctual in his visits or takes advantage of every opportunity, e. g. bad weather or a

legal holiday or a ball game, to stay away, when he develops symptoms (e.g. headache) that compel him to skip a treatment, when he suddenly acts as if he were stupid and couldn't understand or had forgotten what the analyst told him, persists in talking about the trivialities of the day's occurrences, etc.,—in other words, anything that interferes with the progress of the free associations.

The causes for resistance are either the occurrence of coarsely sexual memories which the patient is unwilling or ashamed to acknowledge, a disturbance in the relationship between the patient and the analyst (e.g. a loss of confidence, jealousy, hatred, suspicion, love, dislike, etc.), impatience at the long duration of the treatment, and material (i.e. financial) considerations.

Resistances must be explained to the patient just as soon as they occur and his reasons for them elicited. This is the only way they can be overcome and only then is the patient enabled to continue with his associations or to translate his pathogenic traits and impulses into words. Resistances do not disappear immediately upon their discovery; the patient must be given time to grasp and assimilate the phenomenon. In the meantime he must continue with his free associations strictly according to rule until the resistances have vanished. Only by so doing is the patient enabled to get at the repressed impulses that lurk behind the resistances.

Before we attempt to interpret any of the patient's symptoms or the large mass of data that he places at our disposal we must be sure that there is a well-established rapport (transference) between us and him. Time, sympathy, gentleness, tact, patience and understanding will bring this about. Then, in the light of our experience, our knowledge and his data, we can tell him the meaning of his dream, fantasy, symptom, mood, or impulse. The analyst must be in no hurry to interpret the data offered him; he must resist the temptation to interpret a symptom, etc., as soon as he sees its meaning. Interpretation should be deferred until the patient's confidence is such that he will accept the interpretation without argument; premature interpretation, though correct, will be scoffed at and will beget resistances. It is best to let the patient find the meaning of his symptoms for himself. When this is impossible the analyst will interpret a phenomenon or group of data when the patient is on the verge of finding the meaning for himself, in other words, when the clues are so abundant and significant that the patient will easily see the connection between them and their meaning when this is pointed out to him. Unless the patient's

resistances to the acknowledgment of the existence within him of a certain impulse, instinct or complex, have been gradually overcome the revelation of such an impulse, etc., will do him no good. Mere knowing does not cure; nay, more often it harms. "A patient's condition is materially bettered only when his conscious thinking has penetrated to the repressed idea and overcome the resistances responsible for the repression" (Freud); in other words, when he has become sufficiently the master of himself to realize that he forced these things out of his consciousness and what made him do so.

After a certain complex or impulse has been determined (recognized) it is a good plan to explain this to the patient, its origin, its significance, its universality, the reasons for its repression, etc. If the interpretation is correct and the patient's resistances have been overcome he will at once acknowledge it, will assert that he feels that the interpretation is correct, and will recall a store of "forgotten" facts to prove its truth. If his resistances have not been overcome he will reject it vehemently, contemptuously, argumentatively. The more emotional his rejection the surer the analyst is of the correctness of his interpretation, for the interpretation evidently affects the patient more than it should if it were false.

There is nothing more important in psycho-analysis than the analysis of transference. The notion generally current among non-analysts is that by transference is meant that the patient, male or female, is in love with the analyst. This is only half true. By transference we mean that the patient unloads all his emotions—love, hatred, jealousy, contempt, admiration, etc.—upon the analyst as these well up from the unconscious. Now it is one emotion and soon another. In each instance the analyst is being unconsciously identified with the personage involved in the surface-coming complex. The patient is living over again some incident in his past and is transferring the evoked emotion upon the analyst because he is the most convenient personage for the purpose. The emotion is evoked and the patient "lets it out" on the analyst. Unless this is explained to the patient it will become a source of great resistance and an effectual block to the further course of the treatment. *Positive transference* (i.e., love, admiration, etc.) is as much a bar to the continuance of free associations as *negative transference* (i.e., hate, jealousy, etc.). To one we love and admire, and whose love we want, we can no more confess things we are ashamed of than to one we hate. It is a good rule

to say nothing about transference until this threatens to become a cause of resistance. Only very rarely is it necessary to say anything about it at the first few sessions. Positive as well as negative transference may manifest itself even at the first session and make the patient dumb. The analyst must not wait for the patient to give utterance to his transferences. Actions speak louder than words. One of my patients, a "frigid" woman, enacted her strong positive transference at the first session by refusing to speak until I permitted her to sit so that she might face me,—that she might, as she later confessed, see whether she excited me sexually, although at the time she said she did it because she could not speak to a person unless she looked him in the face.

The analyst must be on his guard against *counter-transference*, that is, against developing love or hate for his patient. Once this happens,—good night, analysis! The best way to combat this is by the constant analysis of the emotions evoked by the patient, by discovering the reasons for the emotions evoked and if necessary, by "having it out" with the patient. Don't try to overcome it by repressing it. If you are developing a dislike for the patient because he is lying, full of complaints, backward in paying his bills, dissatisfied, inclined to come late, disposed to consult another physician, etc., tell him of it. Don't forget that when the patient does these things he is speaking to you, he is showing you his other self which you must have the skill to recognize and interpret. The patient's likes and dislikes are all transferences and do not appertain to you. A good psycho-analyst will turn everything to account to make the patient talk,—and thus he will come very near to extracting sunbeams from cucumbers. The patient is taught "to pick good from bad, and by bad mend."

If the patient worsens at any time during the analysis neither patient nor analyst must be discouraged thereby. The impairment is temporary. The surgeon who is engaged in removing a foreign body from the brain of an epileptic is not disheartened or deterred from completing his task by the occurrence of a convulsion. The patient is raking up certain past disagreeable or painful experiences and the emotions associated with them and aroused by them become actual and present. What he failed to give vent to at the time he is giving vent to now. A present and known enemy can be dealt with better than one that's past and unseen. Probing a wound may be painful; but the discovery of the offending agent puts the remedy in our hands.

It is rarely advisable to undertake the analysis of one's relatives or intimate friends. Young children have been successfully analyzed but none but experts should attempt this. Persons over fifty do not, as a rule, make satisfactory patients. Hysterics with intense acute symptoms e.g. profound depression, excitement, convulsions, etc., do not lend themselves to immediate analysis. Excellent results have been obtained in a few paranoiac and early paraphrenic patients, but these cases should be reserved for experts. Any person with ordinary intelligence can be treated by psychoanalysis, although excellent results have been obtained even in adolescents of less than average intelligence. Giddy, flighty girls and young women who wish to be "interesting" make poor patients. There is hardly anything less promising than the analysis of poor unfortunate—or unfortunate poor—hysterics in our State Hospitals. Notwithstanding all these *contra-indications* to psychoanalysis the fact remains that this method of treatment is applicable and beneficial to more and graver cases than any other method.

For further instructions as to the technique the student is referred to the writings of analysts the world over, especially those published in the following periodicals: The Psychoanalytic Review (New York), Zeitschrift für Aertzliche Psychoanalyse, Imago, Jahrbuch für psychoanalytische u. psychopathologische Forschungen and the no longer published Zentralblatt für Psychoanalyse. To acquire a thorough knowledge of the art and science of psycho-analysis one should devote his nights and days to the study of the writings of Professor Freud. But even this will not take the place of the training one acquires in submitting himself to a psycho-analysis. The successful analyst is one who is "complex-free," that is free from the dominance of unconscious complexes. Every unanalyzed complex in the analyst constitutes a "blind spot" (Stekel) in the mind's eye of the analyst which will not enable him to see the corresponding complex of the patient.

After this all-too-brief resumé of the Freudian technique we are in a position to consider the *modus operandi* of psycho-analysis as a therapeutic agent. There is probably not a single analyst who, after he had explained the theory, has not been asked: "but how does this cure one of nervousness?" It is this question we propose to answer now.

1. **Abreaction or Catharsis Through Speech and Action.**—It often happens that for various reasons a person cannot give

free vent to his emotions and is compelled to repress them, forcibly to forget them. If the attempt at repression does not wholly succeed the offending complex manifests itself in symptoms. Psycho-analysis gives the patient the opportunity to give free vent to the emotion which is the essential part of the complex; and he may do this without subsequent regrets or remorse. Let us illustrate this from our own experience. Mr. B., aged 43, married 17 years, passionately fond of his wife, suffering from acute pathological jealousy, suddenly becomes sullen, surly, restless, sleepless, irritable, and—impotent. After the usual protestations that he knows no cause for his condition he succeeds in calming himself sufficiently to begin his free associations. He then pours out this tale of woe: A few days before the occurrence of the impotence his wife had bought a pair of white shoes although he had asked her to buy grey ones; he regards white shoes on a woman as a badge of an unchaste mind but he would not tell his wife this; he was ashamed to confess it and he intensely resented her non-compliance with his wishes. He gave free vent to his thoughts and emotions—and was at once cured, as I was informed the following day. It was a conflict between love and hate. The attempt to repress his emotions required the expenditure of a large store of psychic energy and was accompanied with decided feelings of displeasure. The talk under the favorable circumstances furnished by the psycho-analysis did away with the repression and thus did away with the accompanying displeasure. The restrained impulse discharged itself in speech and action (vigorous language, pounding the table, walking up and down excitedly, etc.).

The “talking cure,” as Breuer’s first patient very appropriately called his method of treatment, robs the complex of a large part of its affect. In all this there is nothing very new or startling; it is probably as old as humanity itself. Shakespeare, the greatest psychologist before Freud, expresses this idea in the words: “Give sorrow words; the grief that does not speak, whispers the o’er-fraught heart and bids it break.”

2. Confession.—That “confession is good for the soul” is the experience of all mankind. The history of criminology furnishes almost daily illustrations of the need for confession. Guilty persons do not seem to be able to go about comfortably with the secret of their crime in their own keeping. The neurotic is exactly like the criminal in this regard. In some respects the neurotic is indeed an unconscious criminal and sinner. He is one who has re-

pressed forbidden impulses and desires out of fear of his environment, his God and himself. His unconscious guilt isolates him from his environment; he regards himself as being different from those about him; he knows that he is considered peculiar, eccentric. Because of his "peculiar" and "wicked" dreams and fantasies he looks upon himself with awe; he is mystified; he doubts his sanity and broods on suicide. In the psycho-analyst he finds a kind, patient, sympathetic father who hears and forgives all, imposes no penance, does not scold or upbraid, does not threaten or command, and makes no unreasonable or impossible demands. In this way psycho-analysis furnishes the most favorable opportunity conceivable for the abreaction of unacted sins. Psycho-analysis differs, however, from religious confession in being free, voluntary, devoid of fear, untainted with superstition, and conducted in a scientific manner. The neurotic confesses not only the things he did but the things he wished and feared to do, as well as the wicked desires he had "forgotten" and, perhaps, never consciously known.

3. Enlightenment.—Many neurotic symptoms are somatic expressions of ignorant ideas entertained by the patients. These symptoms are really a kind of conversion of the psychic into the somatic. Explaining away the error will very quickly, if not at once, get rid of the symptom. Thus one of my patients, R. P., a young man at college, sexually "abstinent" though consumed by intense sexual desire—and impecunious too—had for many months suffered from distressing gastric symptoms, such as nausea, eructations of an offensive character, regurgitation and morning vomiting of a thick, yellowish, offensive fluid, almost constant heartburn, etc. He was treated for nervous dyspepsia at one of our hospitals for months; then he was shifted to the stomach department; but all in vain. Then he was referred to me by Dr. Berkowitz. During our second session I discovered that he had been masturbating once or twice a week during several years; that he feared that the loss of semen would weaken his intellect because the semen was vital substance which came from the brain or spinal cord; that in order to conserve this precious fluid he held his penis tight at the moment of the ejaculation and thus forced the semen to go backward into the bladder; that from the bladder the semen went up into the stomach through a tube connecting these two viscera and that there the seminal fluid underwent fermentation or decomposition and generated waste substances of an offensive kind which gave rise to his symptoms. I set him right on these points

and he was cured. I have had two patients who were greatly benefited when they learned that the biblical injunction "Thou shalt not commit adultery" does not mean "thou shalt not masturbate." Psycho-analysis is a kind of re-education not only in the higher sense of character building but also in the more general sense of the word "education." But this must not be permitted to be an excuse for spending hours in teaching patients the things they should have learned at school.

4. Relief of Fear.—One of the important results of psycho-analysis is the conviction that the patient gets that his ailment is purely psychic, that it has its origin in his emotional life, that it is understood, has no serious organic basis, is not of a desperate nature, is curable, and is not a manifestation of bad heredity, degeneracy, or insanity, and is not the result of a curse, the evil eye, or of being bewitched. In this way the patient is relieved of a large part of his fears and apprehensions. He thus becomes more contented, more hopeful and more cheerful. The victim of pollutions is immensely relieved when he learns that nocturnal seminal emissions do not result in tuberculosis, general debility, impotence, loss of manhood, insanity, etc.

5. Re-adjustment of Affect.—Some of the symptoms in hysteria are the result of the splitting off of the affect from a painful idea and of its association with another idea to which it does not properly belong. Such a symptom is cured when the patient discovers the idea to which the displaced affect belongs, thus dissolving the false association. A patient of mine, Miss R. L., aged 18, "keeping company" with a young man whom she greatly loved, suffers from hystero-epilepsy and obstinate insomnia. One night she falls asleep for a few minutes and dreams of meeting a bride the day after her marriage; a girl friend (not she!) with whom she is walking asks the bride whether she and her husband "had gone to sleep after the wedding." This furnished the explanation for the patient's insomnia. "To go to sleep" was to her a symbol for indulging in coitus; she was in a state of sexual hyperesthesia and was struggling with temptation; her resistance against "going to sleep" with her lover found expression in her resistance against sleep. She also feared to sleep because of the sexual orgies that occupied her sleeping thoughts (dreams) nightly. After that day she slept well.

6. Re-conversion.—Perhaps the most frequent "mechanism" in the production of hysterical symptoms is that known as

"conversion," i. e. the substitution of a somatic (motor or sensory) symptom for an idea. What happens in these cases is that the offending idea disappears from consciousness and is replaced by an exaggerated innervation (exciting or paralyzing) of a sensory or motor nature. An example from my practice will illustrate this. A young man, aged 32, single, living with an elderly mother who holds in trust for him some money bequeathed him by his father, owns and manages a small store which does not satisfy his ambitious nature. For years he has been suffering from a very severe mixed neurosis. Suddenly he begins to be troubled with a very annoying sensory symptom: he smells illuminating gas wherever he goes. He keeps himself and his clerk busy in the search for the leak. After months of suffering we analyze the olfactory hallucination. He was disgusted with his store and was anxious to be rid of it. The thought occurs to him one day to bring about the destruction of the store by a gas explosion at night, collect the insurance, borrow some money from his mother and open a "large business." Borrowing money is repugnant to him, especially from his mother. Why not cause her death too by an accidental explosion? He struggles with these horrible ideas and succeeds in repressing them; but soon thereafter he begins to be troubled with the obsessive olfactory hallucination. His symptom was a warning to him to beware of leaking gas. With the analysis the symptom disappeared. Such phenomena as this we have just discussed seem to serve the purpose of warnings, reminiscences, revenge, self-chastisement, protection from temptation, the cunning extortion of love and attention, etc. The tendency of guilty thoughts to express themselves in hallucinations is admirably illustrated by Shakespeare in "Macbeth" (II. 1, 99-107) and "The Tempest" (Act 3, Sc. 3, 95-98). Macbeth, aghast at the murder of his sleeping king, tells his wife:

"Methought I heard a voice cry, "Sleep no more!

Macbeth does murder sleep,—th' innocent sleep." . . .

Glamis hath murder'd sleep, and therefore Camdor

Shall sleep no more; Macbeth shall sleep no more!

The Thane's hallucinatory prophecy was fulfilled. Macbeth punished himself and the punishment fitted the crime. (*Lex talionis*.) There is no more uncompromising and unrelenting judge than a neurotic punishing his own—real or imagined—trespass.

7. Substitution of Affect.—The repression of an emotion of which the individual conscience does not approve is not infre-

quently followed after some time by the appearance of the opposite emotion. Repressed hate is replaced by manifest and exaggerated love, repressed love by manifest hate, repressed desire by manifest aversion, etc. The manifested affect is a defense reaction, i. e. an attempt on the patient's part to guard himself against the repressed affect and to rehabilitate himself in his self-esteem. A patient of mine, a girl of eighteen, suffering from a complicated case of agoraphobia, was unable to dress herself unassisted because she could not bend her head down or look into a mirror without getting an attack of palpitation and dizziness. Analysis disclosed that she had been accustomed to masturbate by candle light in a dark bath-room while standing over a mirror. Each onanistic orgy was accompanied with palpitation, faintness, and fear of discovery. Her inability to look down or into a mirror came after she had decided to stop masturbating, and represents her struggle against the evil habit. The symptom was really a preventive measure invented by her to enable her to circumvent the persisting desire.

Mrs. W., a young, married woman, frigid, suffering from frequent attacks of hysterical syncope, is extremely solicitous for the welfare of her husband, though she frankly admits she does not love him. At night the moonlight shining into her bed-room and lighting up the floor fills her with alarm because she fancies she sees her husband laid out for burial. Analysis easily reveals that she made an undesirable marriage in a fit of desperation and that she longs for the freedom that her husband's death would bring her. The intense hatred for the husband is converted into extreme solicitude.

A slightly more complicated mechanism is manifested in the typical case of apprehension neurosis in which a young lady is morbidly afraid of dogs. She is unconsciously in love with her father, is solemnly dedicated to celibacy. Analysis shows that a dog is to her a symbol for "animal passion" and represents her father. In her attempt to repress her incestuous love for her father she converts her desire into fear and, owing to her fear of her father and of the sexual urge, she substitutes "dog" for "father."

The substitution of disgust for desire is excellently illustrated by the following case. Miss K., aged 32, school-teacher by profession, has been suffering from very severe depression, attacks

of giddiness, and total inability to do her work or mingle with society. She has had, as she avers, no serious love affair and is so innocent of all sexual knowledge that she doesn't know why procreation requires the co-operation of both sexes. At the very beginning of her treatment I encounter a very serious difficulty: she cannot board a train without becoming nauseated and dizzy. The matter is serious because she has to travel several miles to reach my office. Centering our attention upon this symptom we soon discover that as soon as she enters a car she sees the persons sitting opposite her, especially if they happen to be fat men, as if the front part of their garments had been cut away so as to expose their genitals to the public view. It is this hallucinatory vision that disgusts and sickens her. There is no doubt that her disgust was the reaction to or conversion of her intensely repressed sexual desire and sexual curiosity. With this analysis the symptom disappeared.

8. Suggestion.—The opponents of psycho-analysis are wont to attribute the good results obtained by this method of treatment to suggestion. There is undoubtedly much truth in their contention. Mild cases "take suggestion as a cat laps milk." That is why they are "cured" by all sorts of quackery. The really difficult cases, the only ones that should be subjected to psycho-analysis, not only do not respond to suggestion but resist it. In my experience neurotics respond promptly to "bad suggestions," i. e. to such suggestions as tend to shake their confidence in the physician, in the method of treatment, and that tend to make them worse or to increase their apprehensions. A real neurotic is always on his guard against curative suggestion; he resents the imputation that he is shamming, that his disease is not real, that an act of the will or a mere matter of belief can rid him of his malady. He argues that a "bad suggestion" must express the truth, whereas a curative suggestion is thrown out only to make him believe something that is not true. The underlying reason for this attitude seems to be either the masochistic element that plays an important role in all neuroses or the conflict with the "parent-complex." Where suggestion seems to do good the result is undoubtedly due to strong positive transference and means the subjection of the patient's mind to that of the analyst, the effacement of the patient's personality—an effect that ultimately does the patient more harm than good. That is why a conscientious analyst will cautiously guard against anything merely suggestive. Psycho-

analysis strives to make strong and independent personalities, not slaves.

9. Transference.—Positive transference for the analyst is favored by the relief the patient experiences from absolution and catharsis. An important result of this improvement is that the patient gains additional confidence in the physician, the psycho-analytic theory and the technique, and takes a lively interest in them. In other words, the invalid takes a scientific interest in himself, learns to look upon himself objectively and to study the origin and meaning of his symptoms with the ultimate object of getting rid of them. He is interested in learning the mechanisms of his symptoms and the pettiness and unworthiness of his unconscious motives. With self-knowledge comes the resolution to take a livelier interest in the world, to take his proper place in the community, to face his duties manfully, to assume the normal relationship to his associates. The more he does this the more he becomes attached to the physician to whom he owes his improvement. In addition to this the analysis of the repressed complexes liberates a considerable amount of libido (sexual energy in its broadest sense) which inevitably affixes itself to the person who most occupies the patient's mind—the analyst.

Transference may prove a very serious obstacle to success in the treatment. The neurotic hungers for love and praise; fearing to lose the analyst's esteem he inhibits the free flow of his thoughts and resumes the critical (i. e. subjective) attitude to his associations. Thus one of the greatest aids in the treatment becomes one of the worst obstacles unless the analyst is skilled enough to recognize it and turn it to good account. Strict compliance with the psycho-analytic rule to talk right on should be the sole means of purchasing the analyst's commendations. Successful analysis of transference places at the patient's disposal an amount of libido which he will then bestow where it properly belongs. In this way the patient is not only made independent of the physician but also brought in the way of resuming his relations with the world.

During the course of the analysis it often happens that symptoms of a transitory nature suddenly make their appearance. These inevitably bear a direct relationship to the physician who is now the substitute for some individual who once upon a time figured as the principal in some repressed experience that the analysis is restoring to consciousness. The patient is living over some phase of his past; but, owing to the neurotic craving to link his fan-

tasies with realities, he treats the analyst as if he were the person involved in the affair. Such a transitory symptom is an extremely subtle and often effective manifestation of resistance. Its successful analysis works wonders in overcoming the patient's resistances to the communication of his painful memories, and in convincing him of the truth and value of the method.

To illustrate these remarks let me refer to three cases from my practice. Mrs. —, neurotic and totally frigid, extremely sentimental, worships men of an intellectual type (like her father, brothers, and a former lover); married, at an advanced age, to a very estimable man who, unfortunately, is not intellectual. One day, while telling me of a visit she once paid to a well-reputed dentist, and noted as a flirt, who caressed her hands and thighs with his unengaged hand, she suddenly stops her narrative and complains of a severe toothache. Knowing that she had not complained of any trouble with her teeth I remark that she evidently wants me to play the role of the amorous dentist. She laughs incredulously, or guiltily, but is amazed at the sudden disappearance of the pain.

Mr. M. finds it impossible to associate freely if he does not face me. Analysis shows that he identifies me with his beloved father and that he thinks it disrespectful to sit with his back to me.

Miss K., formerly mentioned, finds it very difficult to continue her treatment because she is unable to pay for it. She identifies me with her hated father to whom she will not be under obligations for anything, not even her health.

The successful management of transference will inevitably stimulate the patient's desire to be cured—without which nothing can be accomplished. But the analyst must not forget that the desire to be cured is not in itself sufficient to bring about a cure. The patient does not know how to cure himself and the desire for health is not sufficient to overcome the resistances. This can be accomplished only by positive transference.

10. Sublimation.—Psycho-analysis does these things for the neurotic: it restores to consciousness the memory of repressed early emotional experiences, unravels the genesis and evolution of his symptoms, brings him to a realization of his true motives and desires, convicts him of self-deception, cowardice and infantilism. This knowledge enables him to assimilate his complexes, to make them subject to his reason and to his better self, to deal with them in an honest, manly way. But with this the treatment is not at

an end. What is the patient to do with the energies that he is no longer expending in symptoms? He must be taught and encouraged to sublimate them, i. e. to expend them in higher and socially approved activities, such as civic work, art, literature, social welfare, the faithful and skillful discharge of his duties to his employer, religion, etc. In this way psycho-analysis undoes the mischievous work of faulty early education and bad childhood environment—the factors responsible for the failure of sublimation that laid the foundation for the subsequent neurosis. The patient's future is one of the most important and difficult problems for the analyst. The patient's education, talents and opportunities must determine the analyst's goal.

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PERSISTENT SEXUAL LIBIDO IN THE AGED.

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IT is nearly thirty years since Séré, of Paris, described the male climacteric, a condition analogous to the menopause of the female. In the male, this period usually passes unnoticed as it produces no physical discomfort, it proceeds gradually and there is no violent disturbance as occurs in the female. Coming on about the time that the first senile changes are noticed, the gradual loss of libido and potentia are looked upon as part of the normal process of getting old. It is not a senile change though Séré failed to distinguish between this and the process of senescence, for in his description of the male climacteric he included among the symptoms some of the manifestations of ageing. The changes in the male climacteric are essentially functional and there are few or no anatomical changes. The anatomical changes in the male generative organs occur much later and are due in part to disuse, in part to the impaired nutrition which is the basic cause of the general waste of tissue in old age. In the normal male climacteric there is a gradual loss of libido and potentia, the two waning together. About the same time the physical powers wane and the exertion of copulation becomes irksome.

Other factors which further tend to diminish libido and potentia are, changes in the skin making it less sensitive, atrophy of the testicles and seminal vesicles with consequent diminished formation of semen, (a senile change), lessened irritation produced

by the diminished amount of semen, this irritation being a call to empty the filled vesicles similar to the call to empty the filled bladder, rectum, breast glands, etc. Medical science does not deal with esthetics and it may not be pleasing to contemplate, still it is true that while indulging in the gratification of sexual desires, we are simply emptying filled secretory receptacles, at the same time emptying them in the manner contemplated by nature for race perpetuation. When those vesicles are full they must be emptied, and if they are not emptied consciously and voluntarily they will empty themselves in nocturnal emissions, just as the overfilled bladder will empty itself in dribbling or in nocturnal enuresis, and the breasts will overflow when the milk is not drawn off.

As the libido and potentia wane and the sexual act itself becomes more difficult and fatiguing, special stimulus is required to arouse sufficient desire and power to overcome the reluctance to endure this task. There is rarely the spontaneous desire such as occurs in youth when the vesicles are filled, and which is followed by nocturnal seminal emission if not gratified. Nocturnal seminal emission is rare in the aged, but prostatorrhea, which is almost always mistaken for seminal emission, is rather frequent. Complete impotence which resists every stimulus, psychic, medicinal and mechanical, is seldom met with even in very old age. Potentia without libido is very rare but libido without potentia is sometimes found, the libido being either restricted to a particular female or else the knowledge of his impotence keeps the person's mind centered upon his infirmity and there is a persistent desire which sometimes leads to perversions.

A recrudescence of desire and power sometimes occurs during the senile climacteric and is then a symptom of senile dementia. This may reach the state of sexual *furor* and the old man, not realizing the criminal nature of rape, will assault a child or young girl, these being less resistant and more easily frightened and bribed than older girls. Occasionally there will be a recrudescence of desire after years of defervescence as the result of some particular stimulus. I will give a few examples of such cases.

CASE 1.—An inmate of a Soldiers' Home, aged 73, visited friends in the city. During the night he entered the room of a child of 14 and attempted to assault her. She screamed and her parents rushed into the room. They found him standing in the room with a stupid leer, apparently unconscious of the gravity of the offence, making no excuse for his presence in the room. He was arrested, charged with rape. I did not know then that sexual furor during the senile climacteric was a symptom of senile

dementia and the defence turned upon the question of the character of the crime. It was shown that he had a shrunk organ almost imbedded in an enormous scrotal hernia. He had not been away from the home in many years and his reputation was good. He was discharged through disagreement of the jury and shortly afterwards senile dementia became pronounced and he was sent to an asylum.

CASE 2.—A locksmith aged 75, a widower for forty years, lived with a widowed daughter and her four children. His wife died in childbed in convulsions, and this affected him so strongly that he determined never to marry again or have sexual relations with a woman. For several days before I saw him he was morose, irritable and reticent and for two days he refused to go to his shop. One of the daughter's sons coming home about midnight, found him sitting undressed on the edge of the bed, muttering to himself. His daughter, a woman of 45, was sleeping with a daughter about sixteen. Shortly after the son came home the old man went into his daughter's room, stark-naked, in a highly excited erotic state and kept saying, "ich muss" (I must). He began to plead but when the woman called for help he tried to force his way into their bed. It required the strength of the five to hold him. He suddenly collapsed and had a convulsion and was in this condition when I saw him. He was put into a warm bath where ejaculation of a few drops of semen occurred. After a hypodermic injection of morphine he was put in bed. I saw him the following afternoon. He had no recollection of the night episode but thought he had spent the night with a woman and was depressed with remorse. About a week later he again became morose and irritable and fearing a repetition of the attack he was kept under sedatives for several days. After that the daughter kept her room door locked at night and on several occasions during the following three months the old man went to her room and finding it locked he returned to his room. He had no recollection of these visits the next morning, and believed that the family made these accusations to get rid of him.

CASE 3.—The following is a case of persistent libido in an old man. This man is now 84, mentally and physically well preserved, intensely egotistical, and fastidious in dress. His wife died in 1904 and a year later he married his young housekeeper. For years before his wife's death he had boasted of his many liaisons but this was looked upon as the silly bragging of a con-

ceited, impotent, old man. Soon after his second marriage the young wife complained that she could not satisfy her husband's desires, that he gave her no rest even during her menses. Some time later she found that his boasts of having many female admirers were facts, that there were several unmarried women, women whose husbands were away from home much of the time, and widows, who had not paid rent in years. As the marriage was one of convenience and not of love, she did not interfere with his relations with his tenants, but when one moved away his demands upon his wife increased. I recently had an opportunity to question both. He says his desires are as keen as ever, that he still has the power to perform the sexual act, but that he becomes exhausted when through and must lie in bed for an hour or more to recuperate. Still he must have intercourse daily, else his mind dwells upon the omission and he cannot sleep. His wife corroborates his statements. Occasionally he will miss a day and he will give her no rest the following day. It seems that some of his favorite tenants are "out" when he calls, and if his wife will not gratify his desires he flies into a temper, becomes abusive and threatening and even uses force to compel her to submit. He has had no children with either wife.

CASE 4.—The following case is typical of many senile cases. Two years ago a man, now 72, complained that he had lost the power of erection although his desires were still keen, in fact since he realized his complete loss of power his desires became dominating. Up to five years ago he could gratify his desires once or twice a week. The power then waned and he was obliged to resort to masturbation before intercourse. Later this was no longer effective and only on rare occasions was there an erection which came on spontaneously, when he had no opportunity to gratify the accompanying desires. He came to me ostensibly for a gastric disorder, but he soon began to speak of his impotence and the gastric trouble was forgotten. He had gone to physicians who gave him medicine which increased the desire but not the power. One physician used locally electricity, another applied a blister. His desires were now uncontrollable, the thought of intercourse, not with any particular woman but with any woman, was constantly before him. He did not want to do anything that might diminish the libido; he wanted the power restored. This is the general demand of old men who retain the libido but not the potency. These cases are easily handled if there is no necessity to maintain

prolonged potency, as there may be if the patient has a young wife. It is possible to produce a temporary local effect by the use of cold water, sounds and the Faradic current. At the same time anaphrodisiac remedies such as bromides, monobromated camphor and the valerianates should be given. The local stimulation is effective for a short time, perhaps only for a few minutes or hours, still long enough to satisfy the patient. In a few weeks the libido is diminished to such extent that the patient will discontinue the local treatment. This has been my experience in more than twenty cases of this kind.

CASE 5.—We occasionally read of the appearance of widows of old men who were supposed to have been unmarried. I am familiar with one such case. The man, who was 68, at the time of his death was a widower for twelve years. After his wife's death he became a devout church-goer, was serious, sedate, often morose, gave up pleasures, even his annual vacations, and he was looked upon as a quiet, passive, old gentleman. About three years before his death he surprised his family by a change in temperament. He again took an interest in life, wore brighter clothes instead of the conventional black, went occasionally to a concert and even took a vacation. It was not known that he had any relations with women and when questioned jokingly, always referred to his loyalty to his dead wife. After his death, among his papers were found a number of pornographic pictures, and literature and a few letters of the same character. The letters were written by a woman who, when she learnt of his death, claimed to be his widow. She declared that he had not missed a day in three years in his calls upon her, she spent her vacations with him and he was as amorous and as active as a young man.

The following two cases of physicians present restored libido under psychic stimulation.

CASE 6.—An elderly physician went to a theatre where bare-legged chorus girls were the principal attraction. He had never seen a show of this kind before. For many years he had little desire or power, not more than once a month and then the libido followed, never preceded, the erection. Upon his return from the theatre he surprised his wife by his ardent advances. His wife submitted to his daily demands for a week, then finding that his renewed affection was due to the charms of bare-legged chorus girls and not to her own charms, she repulsed him. He then became acquainted with one of the girls and went frequently

to the theatre and was seen with this girl at a summer resort. I do not know what the present state of affairs is and do not want to present a guess as a scientific statement. There is a possibility that my guess is wrong.

CASE 7.—I was intimately familiar with the following case. The physician was past 50 when he discovered that his wife, fifteen years his junior, had a lover. He developed so strong an aversion to all women that he refused to treat female patients. About ten years later he joined a club of Bohemians, theatrical men, sportsmen of irregular habits and unconventional manners. One night he accompanied one of these men to his home, met there the man's mistress and another woman and drank with them; the first time he had taken liquor in many years. This aroused the libido but he was absolutely impotent. Humiliated by his lack of virility and nettled by the ironical references to his second childhood he treated himself for impotence with some success. He was determined to convince the one woman who had teased him most that he was still good for something beside writing prescriptions for babies. In two weeks he was in shape to visit this woman, although he was absolutely impotent for other women. An infatuation for this woman rapidly developed and he spent all his spare time with her. He told me then that he had made up in a few months what he had missed in ten years. This relation kept up for about two years, then finding that he had a urethral discharge which contained gonococci, the libido and potentia suddenly ceased. This case presented peculiar social features beside an interesting medical side. After the doctor discovered that his wife had a lover he insisted that the paramour live in the same house and he, his wife and her lover remained on friendly terms. He did this, he said, to show that he had implicit confidence in his wife and for the same reason he turned over to her his property. Yet the doctor had his sleeping room on one floor and the lovers had their rooms adjoining on another floor and unless there were guests at the table the doctor always took his meals at home alone. On one of the rare occasions when he would discuss his family affairs he made up a list showing the dissimilarity between himself and his wife and the similarity between her and her lover in characteristics, temperament, traits and tastes, and expressed the belief that she would be known as her lover's wife. The lovers were married (or, perhaps without the marriage ceremony, she passed as his wife) a few weeks after the doctor's death.

CASE 8.—In a former paper reference was made to a young woman who despite the fact that she is a Sunday school teacher, holds responsible positions and is generally esteemed, does not hold the conventional views concerning matrimony and sexual relations. Her present lover is nearly sixty-five. He left his wife nearly twenty years ago when he found her unfaithful, and until he met this young woman two years ago he was a misogynist. She had another lover then and was faithful to him until he died a year ago. Pity and sympathy rather than affection attracted her to this man and she accepted him as her lover. Their sexual relations were at first unsatisfactory; on his part, intense libido with complete impotence; on her part a desire to satisfy his desires without any sexual desire herself. Later the power returned and now he is a daily visitor being known at her home as her husband.

In nearly all these cases there were extra-marital relations and in all but two there was a recrudescence of desire after a period of sexual quiescence. When an old man marries a wife much younger than himself, the libido is usually aroused; and where an old man has maintained strict marital relations only with his wife to whom he had been married many years, libido and potentia are either entirely abolished or appear mildly and at long intervals. It is only in rare instances such as those that I have mentioned that the libido remains and still more rarely that both are active.

CASE 9.—The following case is out of the ordinary. In 1891 the man married his second wife, thirty years younger than himself. His business took him out of the city for three months out of every four; the fourth month he remained at home. This had been his routine for twenty years before his second marriage and so it remained until his death last year. He was continent when away from home, making up for lost time when he returned. He retained his virility to the end, being as methodical about his sexual relations then as he was when first married.

Women generally lose the libido after the menopause. Occasionally the libido is increased during the menopause, rarely¹ does it persist after this period. A few exceptional cases will be mentioned.

CASE 10.—In a home for the aged where segregation of the sexes is not enforced a female inmate was discharged soon after her admission. Dormitory companions complained that she openly

¹ Instead of "rarely" I should say "quite frequently." And this a normal and not a pathological phenomenon. Editor.

masturbated and some of the male inmates complained that she made sexual advances to them. She was finally caught in the act with one of the more virile of the old men. Investigation showed that several of the old men had sweethearts among the female inmates. This has been advanced as an argument in favor of segregation of the sexes in such institutions.

CASE 11.—A woman now 58 became intensely erotic during a vaginal examination. She declares that before the menopause twelve years ago she rarely had any sexual desires, that such desires were usually aroused only during intercourse. Spontaneous desires occurred occasionally during the menopause and frequently since. Her husband is becoming impotent and is seldom able to satisfy her demands, especially as they come at inopportune times. She is now taking bromides as a "tonic."

CASES 12 AND 13.—In the following two cases there is a bad history, perhaps a hereditary taint. A woman, aged 64, has been a widow for fifteen years. Since her husband's death she has had boarders who received her favors as well as her board. She makes no secret of her libidinous nature and says she can be as good to an acceptable boarder as a young wife. One daughter is the mistress of an old man, another had a miscarriage before her marriage. A son has been in prison for assault upon a woman. The woman says there has been no change in the character or intensity of the libido since she first experienced it as a girl, except for a short time after her husband died.

The second case is that of a woman now nearly 70. Her first husband committed suicide about thirty years ago, the rumor then being that he found she had other lovers. She married again in 1905 (when nearly 60), her second husband being much younger than herself. This husband declared that his wife could satisfy the sexual demands of any man. I lost track of this woman after her husband died about four years ago but heard from a friend that she would not reject the offer of a third husband. A peculiar feature in this case is the family history. The woman was an only child, she had only one child, a daughter whose husband committed suicide, and this daughter has one child—a daughter, married but without children.

CASE 14.—I will cite one more case which has a romantic as well as medical interest. The husband came from Russia when

about 20 and after he had saved enough to start a home he sent for his sweetheart who had remained behind. On the day of her arrival he was arrested for some petty offense aggravated by the charge of resisting an officer, and was sent to prison. The girl after waiting a few days for her lover obtained a situation as a servant, left this place and got another position, and at the time of his release she was working in a cigar factory. A combination of unfortunate circumstances prevented each from discovering the whereabouts of the other. He had americanized his name and before her arrival gave up his position to become a jewelry pedlar, also changed his boarding house. She became acquainted with one of the cigar-makers working in the same shop and married him, the two opening a little cigar store near my office. This was in 1885. In 1904 her husband died of tuberculosis. A lodge to which he belonged attended the funeral and among the members was her early lover. She recognized him and an extraordinary scene followed, the widow falling into the arms of an apparent stranger, calling him by his first name and begging him to remain with her. The matter was clinched a year later when they were married. She had no children with her first husband; with her second she had three in five years. For the purpose of this paper I visited this woman whom I have known for over thirty years. She says she never had a spontaneous libido while married to her first husband and could only arouse a serious response by thinking of her first lover (her present husband). She never experienced an orgasm with her first husband, such as she has experienced repeatedly with her present husband, and she never had an ardent desire for copulation with her first husband though she frequently has had such desires for her second husband and has such desires still, though she is now fifty-three years old.

Two interesting questions arise in this case. Was there a subconscious inhibition to the orgasm when with her first husband, since she could rouse sexual desire only by thinking of her early lover? Is the orgasm necessary for pregnancy? The latter has been repeatedly denied and the statement has been as often made that women have become pregnant when raped while under anesthesia. I have never seen an actual case reported, though even under anesthesia an orgasm is possible. This however is not pertinent to this paper.

PHAGEDENIC CHANCROIDS.

By PIERRE VERRIER, M.D.

PHAGEDENISM seems to have been studied and known from the earliest times and the etymology of the word was given by Celsus, who described under this name, certain ulcers of the genitalia. Babington, Rollet, Cullerier and Follin quote from this writer this sentence: "Ulcus altius et latius serpit," from which it seems that he distinctly wished to describe the serpiginous chancre.

Later on several writers studied the same subject. Carmichael, and before him Fallopius described the ulcer in his "*De morbo gallico tractatus*." Babington connected phagedenism with syphilis and it was only in the XIX century that the notions relative to the process became more exact. Researches were numerous, while clinical study classified the various types.

The etiology has given rise to the most divers and peculiar remarks. Several factors appear to play a distinct part in the origin of this "complication of the chancre," although the principal part played cannot be attributed to any one of them. "They are an effect of the nature of the virus, because they are more frequent at certain times than at others," say Bell and Carmicheal, who thought that phagedenism was the result of a transmission in kind and they based this assertion on a female patient who presented three types of phagedenism.

The falsity of this etiology and pathogenesis was soon demonstrated. Clinically it was proven that "phagedenism often came from simple chancres, medium size or even small, offering no particular malignity." (Pouget, Thèse Montpellier, 1882). Finally, Spirino, of Turin, and Fournier developed the method of confrontation and experimentation, which removed all doubts in this respect. Spirino inoculated phagedemic ulcers with the pus from simple chancres. In one case, Fournier was able to go back to the source of a terrible phagedenism which had destroyed a portion of the prepuce and had mutilated the glans horribly. As origin he discovered on the woman who had transmitted the affection, a small superficial chancre of the right labium majus which healed in a few weeks. A chancre is consequently not phagedenic simply because it has been contracted from a given source; it becomes so for reasons independent of its origin, influenced undoubtedly by various general or local causes. These in their turn

have been made perfectly clear although no preponderant part can be attributed to any one of them.

It was quite natural to just consider the poor general health of the individual. Debility, physiological misery and pregnancy play an important part in the etiology. Struck by the frequency of this complication of the chancre in alcoholics, Ricord created a special clinical type, the "oenophagedenic chancre." Malaria may, perhaps, also come into play, at least this is the opinion of Spirino, while deAzua has recorded the case of a serpiginous phagedenic chancre in a malarial subject. But it must be admitted that this influence of the general health does not explain all cases.

In other cases the writers have invoked as occasional causes, filth, badly applied dressings and stagnation of pus. Robert refers to a case of a patient with soft chancre and phimosis which became phagedenic because the physician placed lint under the foreskin. Finger believes that phagedenism "is frequently the result of external influences; the pressure of a tight prepuce or external irritation for example."

There are certainly occasional causes which may exert a certain influence but the true cause is as yet unknown. With the advent of the microbic doctrines it was natural that an interpretation in relation to these ideas should spring up and for some writers phagedenism was looked upon as a simple septic complication, the result of an infection or a secondary microbic association. Unfortunately, these researches have not been as yet crowned by success as they have not demonstrated any specific organism nor developed an appropriate treatment.

Phagedenism is an infrequent complication of chancroids, the proportion as given by Fournier being 6 per 1000, and in twenty-two years he had only collected 44 cases. At the present time, this percentage is, perhaps, above the reality. In a recent article de Azua (*Annales de Dermatologie*, 1910) only found two cases of serpiginous phagedenism out of a total of 71,000 venereal patients. Perhaps one should perceive in this decreasing phagedenism complicating soft chancre the result of a more perfect knowledge of the laws of antisepsis and a more strict application of cleanliness.

Phagedenism may arise in two distinct points, namely, in the chancroid itself or in the bubo. Fournier had observed the latter site was the more frequent and that usually it gave rise to the more serious types. Rarely in this case is it the consequence of a

phagedenic chancroid; on the contrary it follows a medium sized ulcer undergoing a normal evolution and absolutely devoid of the special malignancy belonging to phagedenism. These observations of Fournier are perfectly confirmed by two cases under my observation. In both the ulcer was benign and the serpiginous phagedenism was a complication of the bubo.

No matter what may be the origin, chancrous phagedenism, which in reality is only an exaggeration of an ulcerative process, may take on various forms, the principal being:

The gangrenous type,

The acute pultaceous type,

The serpiginous type, and

The chronic type of the prostitute.

The gangrenous type. In this variety the region of the ulcer becomes painful and the ensuing serous suppuration is fetid. The violet and grayish points formed on the sore by mortified tissues do not become detached. Others soon form and in a short time the entire chancre is invaded by a scab which blackens, dries and extends in surface and depth. At the end of a few days, the second week at the latest, a very distinct separation takes place between the living and dead parts, the scab becomes detached in strips or en masse, leaving a simple wound. Unfortunately, the deep impression, mutilations and numberless deformities are the vestiges of this very acute type.

Acute pultaceous type. Here, on the contrary, after a regular evolution, the chancre suddenly becomes painful and the surrounding skin inflames. The edges of the ulcer appear more raised, irregular and undermined. The fundus, usually uneven, is covered by a grayish membrane that may be easily taken for a scab, but which rather more resembles a diphtheroid membrane. The pus is sanguinolent; there is a slight rise in temperature. Later on, this type may develop lancinating pain but usually the ulcer cleans up and granulation follows. On the contrary, in other cases the phagedenism extends and then one is dealing with the serpiginous form.

Serpiginous type. This is characterized by a process of repair and cicatrization taking place on the parts first involved, while the ulcer extends. The serpiginous phagedenism consequently does not present a uniform aspect and there are assembled different stages of ulceration and cicatrization. The ulceration varies in size but never extends deeper than the subcutaneous fat. The

edges are irregular. The bottom of the ulcer is gray, covered with a membrane difficult to remove. At other points the aspect is quite different. The edges have fallen in and become glued to the ulceration and the surface is red and granular. At still other points the repair is further advanced with islands of cicatrization either in the centre or at the circumference. According to the degree of repair the configuration varies; usually it is in the form of an irregular cicatrix like a burn, circumscribed on its outline by an ulceration which forms a border for it.

The ulceration offers nothing regular in its progress. Quite often it progresses rapidly in the early stages, later taking on a slower march. At other times it extends in an equal and continuous way. The track that it follows is governed by no rule; it extends in a straight line or on the contrary, it takes on capricious curves.

The duration varies, but in this respect a most reserved prognosis should be given on account of the tenacity of the lesions and the indefinite duration of certain forms. Although some ulcers cicatrize in a few weeks, others in a few months, there are some that persist for years. One of Fournier's cases lasted 14 years, while in a case under my care it had lasted four years and six months, the ulceration having extended to the thigh. Another curious point in the symptomatic history of this ulceration are the recrudescences and unexpected relapses taking place at a time when the progress of repair is most marked or when a cure seems definitely assured and all without the slightest apparent appreciable cause.

Bacteriological researches remain obscure, in the sense that it is as yet impossible to specify the organism which, added to an *ulcus molle*, gives it its phagedenic quality. The examinations have, however, been numerous. Nov. 2, 1902, Bizard and Ribon found streptococci in a case of superficial syphilitic phagedenism. In two cases published by Brocq and Simon, Leuglet found streptococci and in one of them a bacillus singularly like Ducrey's organism. In two other cases of Dominici and Rubens, Duval also found extremely virulent streptococci. In June, 1906, Brault of Algiers reported three cases of tropical ulcer presenting the fusospirillar symbiosis. The latter, however, is not pathognomonic of this type of ulcer and in 1906, Balzer and Foisot mentioned it in cruro-vulvar gangrenous *ulcus molle*.

The scrapings taken from a phagedenic ulcer of the calf of the leg when stained by Nicolle's method, revealed the bacillus of Ducrey and some unimportant cocci. This organism slightly stained at its middle, offered the characteristic arrangement in chains and was found identically the same in an ulcer on the penis.

On the other hand, neither in the exudate nor in the scrapings of a venereal serpiginous ulcer in a malarial patient could de Azua find the Ducrey; but in the secretion removed on glass he discovered a coccus having the same morphology as that already observed by Piocco and Unna, but whose part in the process appeared very uncertain.

In two of my cases microbiologic researches were carried out on several occasions with the result that Ducrey's bacillus was always found and, after a year of treatment with antiseptic applications and hot air the last examination of one of them still revealed in the undermined edges of the ulceration the presence of Ducrey in abundance.

As to the diagnosis, the evolutive characters render it easy in the serpiginous type. The history of the case and a study of the initial lesion makes the recognition of an *ulcus molle* or its *bubo* as the starting point of the process easy.

However, it must be admitted that this form of phagedenism can be easily mistaken for certain serpiginous ulcers of secondary or tertiary syphilis. Ulcerating syphilides are always surrounded by a marked infiltration and the circumference of the lesion is composed of conjugated arches. It is usually an ulcer extending in depth. If, however, it takes on a serpiginous and superficial development, making it similar to a serpiginous phagedenic *ulcus molle* an attentive study of the antecedents will remove any doubt that may exist. In certain cases bacteriologic examination may be necessary to show the presence of Ducrey or to begin a mercurial, iodide or salvarsan treatment in order to detect syphilis.

The serpiginous type of phagedenic *ulcus molle* does not offer locally the same gravity as the gangrenous type. In the former there are no deep impressions, mutilations, deformity or atresia of the meatus which are the ordinary relics of the gangrenous type. It may produce certain consequences such as inflammatory attacks, slight hemorrhage, more or less sharp pain in the ulcerations, progressive debility of the patient resulting from abundant suppuration. A serious anemia or loss of flesh is a frequent result.

One point always darkens the prognosis, namely, the possibility of a recurrence. One should always be suspicious of phagedenism and only mention the word "cure" when every speck of ulceration is absolutely and surely cicatrized. As long as there remains the slightest trace of an open wound a recrudescence is always possible and it may be the most serious inasmuch as it arises at a time when a cure seems the most assured.

To control an affection so essentially malignant and chronic most varied treatments have been proposed. Caustics were formerly much employed; Hutchinson resorted to continued irrigation; Desprez noted several cures from erysipelas. Robert attributed phagedenism in debilitated subjects to a decrease in the number of red blood-corpuscles and ordered a treatment with iron; in robust patients the number of red blood-corpuscles is the same but the fibrin is in excess and in such cases alteratives being indicated, he administered potassium nitrate in large doses. See, in 1880, proposed simply scraping the ulceration and then cauterize with a thermocautery, this followed by a dressing with a solution of chloral and carbolic acid. Surgical interference has been successful.

De Azua advises applications of hot compresses soaked in potassium permanganate and repeated application of the thermocautery on the edges of the sore where extension is taking place.

In two of my cases several treatments were tried successively. First simple antiseptic dressings were applied with compresses soaked in a 1:1000 solution of zinc chloride; afterwards radioactive mud was tried and on the edges at points where the lesion seemed to be progressing frequent application of the thermocautery. Finally we commenced the hot air treatment; energetic applications were made and one of the patients is still under treatment, the other has left the hospital completely cured. Although there is a great improvement in the second case the lesion is far from making the same happy progress as in the first case.

For THE AMERICAN JOURNAL OF UROLOGY AND SEXOLOGY

SILVOL IN ACUTE CYSTITIS.

By W. O. HUMPHREY, M.D., Louisville, Ky.

The physician has long sought for a preparation of silver that could be used safely and satisfactorily for bladder irrigation. It would appear that Silvol is ideal for that purpose.

The following report of its use in acute cystitis is very interesting in view of the fact that it was used in a 30% solution and retained for four or five hours without discomfort.

Mr. H. Age 54. Good family and personal history. Applied to me last February for treatment of a very painful bladder irritation. Urinalysis showed no pathology except the ordinary pyogenic cocci. Cystoscopy showed only a highly congested and thickened mucous membrane. The bladder was irrigated with a five per cent Silvol solution, and about two ounces, or all the bladder could hold, was left in. The bladder was irrigated the next day with ten per cent. solution of Silvol and about the same amount left in the bladder. On the fifth day the Silvol solution was increased to thirty per cent., and now over four ounces could be left in the bladder without discomfort. The patient was discharged on the twelfth day, relieved of all symptoms. At no time was there any discomfort felt from the Silvol solution, but rather a decided sedative effect. One day after an irrigation with a thirty per cent. solution he felt so good that he went to sleep and the solution was retained for four or five hours.

Translated for THE AMERICAN JOURNAL OF UROLOGY AND SEXOLOGY.

NEUROTIC EXOGAMY.

An essay on certain similarities between the mental processes of neurotics and those of savages.

By KARL ABRAHAM, M.D.

WHILE marriage between kinsmen was once considered solely as a phenomenon apt to burden the descendants with certain hereditary characters, I have shown elsewhere¹ that this form of union is worthy of study as a symptom of neurotic psychology. Basing my reasoning upon the idiosyncrasies of neurotics which have been revealed to us by psychoanalysis I have come to the conclusion that many neurotic subjects are unable to experience any libido for persons in no way related to them because their libido remains, even after puberty, a slave to incestuous influences.

For the neurotic who must keep away from the object of his first incestuous desires as much as from women who are not blood

¹ Marriage between kinsmen in its relation to the psychology of neuroses. Jahrbuch für psychoanalytische Forschungen. Vol. I. 1909.

relations of his, marriage with a kinswoman constitutes a compromise.

I pointed out in the above mentioned article that in order to gage correctly the psychological import of the tendency to inbreeding, we must consider it as one unit in a whole series of symptoms. At one extreme end of that series we find actual incest, which is not as rare in psychopathic families as is commonly assumed; at the opposite end of the series we find complete and lasting distaste for all relations with the opposite sex.

A psychological stage close to the first mentioned extreme is a leaning for members of one's family who are not, however, blood relations in the first degree. Quite as close to the other end of the series stands a condition which I would designate as neurotic exogamy.

In such cases the man² experiences an insuperable aversion to enter into close relations with a woman of his own race or nationality, or more accurately, of his mother's race or nationality. In a word he is taking unusual precautions against the possibility of committing incest. The neurotic avoids women of his mother's type and seeks those who in their appearance and make up are quite the opposite of his mother (or sister).

The following case may throw light upon the condition in question:

A neurotic of the blond North-German type shows the most profound dislike for women of the same type. Nothing about a woman must remind him of the object of his first love, his mother. The only women who can attract him are dark-haired brunettes of another race. He has in the course of years showed some friendship for several women, always of a different race or nationality. The tendency to "serial formation" mentioned by Freud, however, was very apparent. For the patient has never been able to direct his libido successfully and permanently toward one special woman. Its fixation upon his earliest love has proved irresistible.

I have had occasion to analyze a large number of similar cases and I have gradually reached the conclusion that such an aversion on a man's part to women of his own race (or of his mother's race) gives us a clue to a certain law.

Weiss published some time ago³ an interesting report of quite

² In this article as in the one I mentioned before, I consider first the symptoms as they appear in the male sex. I gave my reasons for this procedure in loc. cit.

³ Internationale Zeitschrift für ärztliche Psychoanalyse, Vol. II. p. 161.

similar observations. He cited the case of a man who felt unable to marry any girl from his native town and native province.

That man is also repelled by girls whose eyes or hair resemble his sisters'.

Some neurotics fail to realize the origin of that sexual aversion; others are fully aware of it.

A patient of Jewish race told me that he would never marry a Jewess, for he couldn't help seeing in every Jewess his own sister. As a matter of fact that patient was affected by an unusually strong incestuous fixation upon his mother and sister, a diagnosis confirmed by his neurosis (agoraphobia) (?) At the time of puberty he had indulged in sexual contacts with the other children of the family.

Another patient, also of Jewish origin, related to me very similar facts regarding his preferences as to women. He had fallen in love several times with girls who in their appearance were absolutely the opposite of the Jewish type, for instance with a blonde Danish girl.

In a third case, conditions were exactly the same, but the patient didn't realize the origin of his racial sympathies and antipathies.

In all the cases I could investigate closely, I observed, besides an irresistible positive fixation of the libido upon the next of kin, a decided hatred of the patient for his own parents. In certain cases the patient hated his mother, a feeling due to a disappointed incestuous love; in other cases the patient hated his father, a fact due to the Oedipuslike position the son found himself in.

Such a feeling of hatred is for the son a strong incentive to go away from his family. He seeks to break not only the bonds that unite him to his blood relatives but all relations with the rest of his family.

A new light is thrown on frequent phenomena of two different kinds by considering them from this angle.

The first class of phenomena I intend to touch upon is a number of the so-called mixed marriages. I allude especially to the intermarriage of Jews and Christians in countries where the majority of people are of the Christian faith. It is in some cases the fear of incest, in other cases an aversion for one's family which is not infrequently at the bottom of mixed marriages. I could trace many instances to that cause.

I also wish to call the reader's attention to a class of men who at a very early age, most of them yielding to the thirst for independence which characterises the period of puberty, leave their native country and marry a woman of a different race in some exotic land. I have on hand a whole series of very instructive observations on that subject.

Freud's latest investigations have pointed out to us certain similarities in the mental processes of neurotics and of primitive races. In this connection we may recall the marked aversion to incest noticeable in both neurotics and savages. This fear of incest expresses itself most strongly in the legislation of some ethnical groups whose greatest concern is apparently to prevent incest. The most effective and far reaching measure of that sort is the custom, adopted by many primitive tribes and known as exogamy. It forbids sexual relations not only between blood relatives in the strict sense of the word, but even between members of the same tribe.

We have seen that many neurotics, prompted by an inner urge, only feel a leaning toward persons belonging to a different race. In these neurotics the inner urge has the same effect which an outward, lawful form of compulsion has upon men of primitive tribes. We are therefore perfectly justified in characterising the phenomena we observe in neurotics as exogamy. The neurotic and the ethnological phenomena which we designate by the same word have absolutely identical origins and identical aims.



Editorial

WHEN IS COITUS MOST LIKELY TO RESULT IN CONCEPTION?

In the April issue of *THE AMERICAN JOURNAL OF UROLOGY AND SEXOLOGY* we had an abstract of a paper by Dr. Siegel, in which he gave the results of a study of 100 cases of conception in which the time of coitus could be definitely ascertained because the fathers were soldiers sent home on very brief furloughs.

He has now investigated 220 more cases and the results are essentially the same as those obtained in his first series. They

demonstrate that the most likely time for conception is during the first days after menstruation. The likelihood of conception grows gradually less until for five or six days preceding menstruation the woman may be said to be practically sterile.

The probability of conception in the few days following menstruation as compared to the few days preceding menstruation is as fifty to one. Where the soldier came home during the few days preceding menstruation and left before menstruation passed, no conception took place.

Dr. Siegel's findings are very suggestive and may be assumed to be correct. However, we must remember that they only have a relative and not an absolute value. For, as we said many times, there is no day in the month in which the female of the human species may not conceive. The orthodox Jews abstain absolutely from any sex relations during menstruation and during the seven days following menstruation and still they are one of the most prolific of all races. Again we know personally a number of cases where conception took place one, two or three days before menstruation. So there is no absolutely sterile period in a woman's life, but relative sterility may be said to exist.

Dr. Siegel has also been collating data concerning the sex of the child. He divides the 28 days into four periods: The first period is from the 1st day of menstruation to the 9th day. The second period includes five days, from the 10th to the 14th. The third period includes seven days, from the 15th to the 22nd. The fourth period includes six days, which the author does not consider, as during these six days the woman is practically sterile.

A study of 80 cases yielded the following results. The pregnancies which took place during the first period resulted in 37 boys and 7 girls; those of the second period in 4 boys and 8 girls and those of the third period in 3 boys and 20 girls. If a study of a larger series of cases should corroborate Dr. Siegel's results, we would possess valuable data both as to the best periods of conception and as to the regulation of the sex of the child. We would know that the best time for conception is during the two weeks following menstruation, and that if a boy is desired coitus should take place as soon after menstruation as possible, and if a girl is desired coitus should take place seven or eight days before menstruation.

Letters to the Editor

CONTRACEPTION OR ABORTION—WHICH?

Editor AMERICAN JOURNAL OF UROLOGY AND SEXOLOGY:—

The perusal of Doctor Talmey's article in the August number of the Journal is bound to be disappointing to the thoughtful, earnest seeker after truth. The Doctor gives to his article the title "Abortion or Contraception, Which?" but where and when in the fifteen or twenty pages does he answer his own question? Does he believe in abortion or contraception or both or neither? Readers of your journal enjoy facts and arguments and logic but they also want conclusions and here at least is one reader who fails to see wherein Dr. Talmey has arrived at any thing but "glittering generalities" in his lengthy paper. One is at first led to believe by his arguments about the fetus being part and parcel of the mother's body that he believes that for her to seek its removal is no more of a crime than it would be for her to seek the removal of an offending appendix or tonsil and yet on page 353 one reads that it is a crime for any physician to destroy a potential personality. Are we to understand that the Doctor advocates the legalization of abortion but only in the form of "auto-abortion"? Would he have the physician in the position of one who must not commit a murder but who may assist in disposing of the body after the mother has taken her unborn infant's life? He says "the initial operation is easy. Thousands of women perform the same upon themselves." Does then the Doctor want the use of catheters, hairpins, etc., to be made legal if used by the individual herself and make it safe and respectable for the gynecologist to repair the damage she has done to herself?

The modern woman is, we must admit, wise as to the methods to be adopted to bring about an abortion, but her knowledge of her own anatomy and her ability to practice asepsis are practically nil, and it is only by the Grace of God and the marvelous ability of the tissues to resist infection and to repair the damage done through ignorance that any of these auto-abortions result other than fatally to the mother as well as to the fetus. It would seem obvious to any one that if abortions are to be done they should be done as a minor surgical operation by one who is not only

authorized by law to do them but who knows enough about the anatomy of the pregnant uterus to do them skillfully and cleanly and with a minimum of danger to the unfortunate woman's life and future health. To call in a consultant "in time to save the woman's life" seems hardly in keeping with the modern teachings of surgery and gynecology.

Abortions, Mr. Editor, should be legalized, but not by any means all of them. To make it legal to allow a woman, who is abundantly able physically and financially to bear and to rear a child begotten in wedlock, to have an abortion done for no other reason than that she does not want to accept the punishment and restrictions of motherhood would be a crime against society. To deny to a girl who finds herself pregnant out of wedlock, a girl whose station in life is such that to bring a child into the world would be but to hang a millstone about her neck, the relief of a legalized abortion, is likewise a crime.

Such a mother is invariably a social outcast, the innocent fruit of her indiscretion is branded with that unjust and cowardly epithet, bastard, and in a vast majority of instances it is as impossible for the girl to "come back" as for the camel to pass through the needle's eye. To say that to legalize such an abortion would increase the total number of "bad" girls is as absurd as to contend that it is wrong to parole a prisoner or to adopt into a respectable family the child of unmarried parents.

The writer appreciates that in asking that Dr. Talmey be more specific in his conclusions he is stating no conclusions himself, but this letter is not an article upon the subject, but only a friendly criticism of what is otherwise one of the most readable things that has appeared in the Journal.

208 Hamburger Building,
Los Angeles, Calif.

Very truly yours,
A. R. ROGERS, M.D

Miscellany

STERILIZATION OF THE INSANE.

DR. HELEN J. C. KUHLMANN.

IN an article on the subject (*Woman's Medical Journal*, July, 1916), Dr. Helen J. C. Kuhlmann, discusses the question whether it would be desirable to pass a law making Sterilization *compulsory* in certain cases.

The writer believes that in the light of our present knowledge such a law would be decidedly *injudicious*: it would arouse the antagonism of the people, reduce the number of voluntary admissions, and *defeat its own end*.

She maintains that meanwhile we can get along without a law of this kind if we use *discrimination* as we are not dealing with a homogeneous group; she thinks, we must try to obtain the permission for sterilization from the relatives of the patient when the operation appears to be *imperative*. From her own experience in the State Hospital, Buffalo, N. Y., Dr. Kuhlmann cites a few instances where sterilization was *advisable*, and others where an operation would have been *unwise*.

FIRST CASE.—Patient admitted in September, 1907, 22 years old, 3 years before married to a butcher. Patient comes from family in which manic-depressive insanity was rampant, moreover, her mother having had 14 children. On admission patient was suffering from an attack of acute mania and in a condition of marked exhaustion. She was discharged recovered three months after admission. Readmitted in April, 1911: had been well in the interval and given birth to 3 children, two of them twins. Was sterilized in November, 1911. By March, 1912, she was quiet and self-possessed. Six months later, discharged recovered. Is well now since 4 years. Writer thinks tho she might have another attack, her chances are better now when she can bear no more children, and the race is saved from more manic-depressive cases.

SECOND CASE.—Saleswoman, American, 20 years old. Admitted in December, 1910, in a condition of acute maniacal excitement with extremely erotic behavior. Ten months after admission had quieted down sufficiently to be given parole, but was returned

with same symptoms six months later. Examination showed a markedly overdeveloped clitoris and large turgid labia. On account of utter lack of sexual control, permission for sterilization was obtained from parents. The tubes were exsected and the vulva injected with alcohol which was followed by complete anesthesia of vulva. Patient felt less troubled with erotic excitements. Discharged in April, 1914. Readmitted in January, 1915, in a condition of excitement: had quarrelled with family and fallen in love with chauffeur of her employer, a physician. By June, 1915, quieted down sufficiently to leave hospital. Writer heard that meanwhile girl has married chauffeur.

THIRD CASE.—Girl, 19 years old, an imbecile with absolute lack of moral sense. Admitted in May, 1914, on account of an outbreak of excitement. Sterilized and transferred to Custodial Asylum.

FOURTH CASE.—Polish woman, 24 years old, married, suffering from epilepsy. Admitted in March, 1914, when 7 months pregnant. On admittance in an epileptic confusional state, from which she passed into condition of extreme excitement, having 172 convulsions in a month. From April 29th to delivery, May 7th, urine showed many hyaline and granular casts and some albumin. Was sterilized August 4th, went home August 30th. After 6 months writer found her bright and happy and with only 2 or 3 convulsions in a week.

FIFTH CASE.—Swedish woman with poor family history, 34 years old, married, mother of 4 children. On admittance, in May, 1912, presents all the characteristics of paranoid præcox. After sterilization improved considerably but retained the paranoid trend. Was taken home by husband against advice.

SIXTH CASE.—Woman, 37 years old, but of youthful appearance, with good family history, but living with good-for-nothing husband. Broke down after birth of 5th child. On admittance suffering from manic-depressive insanity. As repeated pregnancy was feared, sterilization appeared advisable.

In the following two cases the writer declares that the performance of an operation would have been absolutely *unwise*.

FIRST CASE.—Woman, 31 years old, well-educated, altruistic and reliable; in her family no insanity nor other nervous trouble. For 7 years kept company with a man who intended to marry her, and became her husband 4 months before her baby was born. She continued to worry about the disgrace and after delivery developed

an attack of great depression. Gradually she learned to accept the situation, made an excellent recovery and subsequently had another child.

SECOND CASE.—Woman, 33 years old, developed severe attack of depression after birth of 5th child. A month before delivery had lost 2 children of whom she was very fond. On admission, in 1893, she was desperately suicidal. Improved slowly. Discharged completely recovered in March, 1894. During the present year (1916) writer has seen her: she has four additional children and leads a normal, healthy, happy family life.

Dr. Kuhlmann thinks that in many cases of dementia præcox *the matter takes care of itself* for many are permanent hospital residents, while others shrink from the normal outlet of the instinct—their sex life being auto-erotic and mental rather than reproductive.

THE SOUTHERNER LESS OBSCENE.

The safest foundation for the treatment of sexual matters is to be found in a natural way of thinking and feeling. In a nation which regards the sexual impulse as natural and truly human there will be less tendency to the misuse of that impulse. For this reason, though perhaps in many respects more sensual than the northerner, the southerner is less inclined to obscenity and pornography. A glance at the sexual life of Italy will convince us of the truth of this view.—ROBERT MICHELS.

KEEP AWAY TEMPTATION.

“You cannot take a child into a pastry-cook’s shop and show it an abundance of the tarts and cakes of which children are so passionately fond, without giving it one or two to eat; such a test would be too much for the childish understanding. When dealing with things which childish greediness makes dangerous, it is no use speaking mysteriously to a child of carious teeth and of a disordered stomach; it is better to keep the temptation altogether out of sight. Sexual timidity is a better safeguard against licence than a detailed knowledge of sexual matters.” (Hans Dankberg).

VIRTUE BY COWARDICE.

The worst outcome of sexual enlightenment effected on purely medical lines, arises from the nature of the material with which

such an enlightenment works. Thus, the doctor does not attempt to establish the criteria of normal morality in sexual relationships, but simply endeavors to arouse fear in the youth's mind by depicting in lurid colours the results of sexual excesses. In the best event, he induces chastity only through the fear of syphilis. Thus is fortified a sentiment already far too widely diffused throughout our intellectual and social life, and one hostile to all true progress—the sentiment of cowardice.—ROBERT MICHELS.

THE ADULTS IN NEED OF SEX EDUCATION.

The greatest difficulty of all in connection with the work of sexual enlightenment concerns not the children but the adults, the teachers not the taught. Adults educated on the old systems find it difficult to free themselves from embarrassment when they have to discuss sexual matters with their juniors; their explanations are thus deprived of all natural spontaneity. Indeed, if there be one matter more than all others in which all affectations and all abruptness must be put aside it is this matter of sexual education.—ROBERT MICHELS.

CHASTITY A MEANS, NOT AN END.

Sexual love is one of the primary physical needs of the human race. For this very reason, chastity has a practical value, but it has such a value only as a means to higher ends. As an end in itself, chastity is unnatural and absurd. The sexual need takes the form of an urgent impulsion. In the case of every organ of the human body there is experienced an instinctive tendency to the exercise of its normal functional activity, and the sexual organs share this universal tendency.—ROBERT MICHELS.

THE SANCTUARY OF LOVE.

It is only among a very small number of savage races that sexual intercourse is practised in public. In all the peoples of ancient civilization lovers who wish to engage in the actual service of the god of love withdraw to a holy-of-holies, jealously secluded from the vulgar gaze. Often this sanctuary is some fragrant nook in the woods, where the wild bird is priest and bright butterflies poised on tall, many-coloured flowers are the witnesses—perhaps the most beautiful of all places for the votaries of Eros. Such a place as this will be preferred chiefly by couples whose union is not legally recognized, and is perhaps incapable of such legal recognition; but at times will be attractive to a married pair poetically or romantically inclined.—ROBERT MICHELS.